WIC Futures Study Group

Report on Meeting #5 held June 18, 2008
Crystal Inn, Great Falls, MT

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Introduction

In response to financial, structural, and operational challenges within the Montana Women, Infants, and Children (WIC) nutritional program, the WIC Futures Study Group was convened to evaluate and revise the WIC service delivery system to provide effective, efficient, and high quality services to the greatest number of participants possible.

The fourth meeting of the group was held on Wednesday, June 18, 2008. The following is a report of the meeting activities.

Participants included:

Joan Bowsher	DPHHS/WIC	Tom Mexican Cheyenne	Northern Cheyenne Tribal Health
Mary Beth Frideres	MPCA		
Mandi Zanto	DPHHS/WIC	Bill Hodges	Big Horn County HD
Kim Mondy	DPHHS/WIC	Tara Cutler	HRDC Dist. 6 Fergus County WIC
JoAnn Dotson	DPHHS/FCHB Chief		
Jane Smilie	DPHHS/PHSD Adm.	Riki Handstede	Hill County HD
Ellen Leahy	Missoula CCHD	Kathleen Jensen	Sheridan County HD
Linda Best	Deer Lodge/Beaverhead County WIC	Dorothy Bradshaw	Lewis & Clark CCHD
		Gayle Espeseth	Riverstone Health - Billings
Jennie Siefert	Dawson County HD	Shawn Hinz	Riverstone Health - Billings
Mark Walker	DPHHS/WIC		

The meeting was facilitated by Mary Beth Frideres of the Montana Primary Care Association. The desired outcomes for the session were as follows:

By the end of this session, participants will have –

- Generated solution options for identified problems;
- Evaluated and selected solutions,
- Created a list of recommendations for the state; and,
- Discussed and decided if another meeting is needed and if, yes, created an agenda for that meeting.

Opening Comments

Opening comments were made by Joan Bowsher, DPHHS WIC Director. Introductions were then made and the group reviewed the agenda.

Discussion Regarding Recommendations Already Addressed

Joan reviewed actions taken by the DPHHS WIC program since the last meeting. Changes currently making to the state plan include:

- ❖ CPA requirements – if the person has a health-related degree, they will need only 6 credit hours of nutrition plus education and course work in anatomy and physiology.
- ❖ As of October 1, 2008, DPHHS WIC will not issue non-contract standard infant formulas.
- ❖ The WIC program will not be changing the RD contact requirement for high risk clients.
- ❖ As of Oct 1, 2008, programs will no longer need proof of pregnancy, and DPHHS WIC is reducing the infant/child hematocrit by one.

State staff are also looking at possible signature reductions. Some proposed solutions will be considered for inclusion into the SPIRIT system. Joan also reported unexpected progress toward the development of an EBT system for WIC.

Brainstorming Solutions

The facilitator took each problem statement in the order requested by the group and asked them - "What suggestions, ideas, practical proposals need to be implemented to reach the vision?" Some of the previous problems were melded with problems addressed in this session and solutions were then blended. The following is a summary of this process:

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1. Problems: ***The WIC Program delivery system will not meet our needs in the future.***
Very small clinics are costly to operate.
In some of the regions, administrative and provider tasks are duplicated.

Recommendations:

1. Keep and improve regionalization by:
    a. identifying lead agency responsibilities;
    b. conveying clear expectations; and,
    c. paying lead agencies for their additional responsibilities.
2. Regions with under 200 clients should join with another region.
3. The funding formula should motivate agencies to be a lead and to see more clients (even if they are not a lead agency) like the breast and cervical cancer program.
4. Create regional vendor liaisons.
5. Change state plan so that locals do not have to pay for RD services.
6. Define regional staffing requirements so regions don't have duplicate administrative or other structures.
7. Consider alternate methods of service delivery:
    a. remote access with webcams for CPA certification;
    b. require 3 month issuance of checks except for high risk clients;
    c. for a certified client, when they have used the last check, they can contact WIC through email or phone and next 3 checks will be sent to them (remote access); and
    d. it may be better to hold clinic where or near where clients buy food.
8. Provide guidance to locals about what alternative methods can be implemented.
9. Move toward consolidation of administrative functions within regions - changes can be made through attrition (must consider travel, other costs).

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2. Problem: ***Issuance of non-contract standard formulas wastes time, increases costs, and decreases the rebate.***

Recommendations:

1. Change the state plan to disallow non-contract standard formulas as soon as possible if the regional office will approve it.
2. Develop a plan to implement the policy change, include early notification and education.

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3. Problems: ***Not all local agencies can recruit and retain qualified staff.***
The requirement to be a CPA is unrealistic and/or costly for some local agencies.
Registered dieticians (RDs) are costly and difficult to obtain in some areas.

Recommendations:

1. CPAs
    a. Review CPA requirements for the state.
    b. Review number of college credits needed.
    c. Reset amount of nutrition credits needed to the number required for a college degree.
    d. Review if a person can work immediately and have one year to get the needed credits - or set it up so that a person can obtain half of the credits the first year and half the second year (while working).
    e. Provide a course by RDs to get needed CPA credits – deliver this at several sites.
    f. Encourage regional consultation and training.
2. Registered Dieticians (RDs) – Regional approaches and centralized approaches must be considered due to expense and availability:
    a. Change the state plan so that locals do not have to pay for RD services, i.e. set up a state-contracted RD who locals can call for phone consultation.
    b. Consider web-cam RD consultation - could be centralized out of DPHHS or regional.
    c. DPHHS to research if Medicaid can be billed for services via webcam.
    d. Research how many RD hours are needed to help the number of high risk clients.
    e. Research if Medicaid can be billed for Targeted Case Management and EPSTD.
    f. Consider central or regionalized billing.

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4. Problem: ***Very small clinics are costly to operate.***

Recommendations:

1. Cap the cost per client; or, provide a flat rate per client.
2. List and distribute new ways services may be delivered as described, above, (3 months o of checks, mailing checks after phone or email contact, etc.)
3. Part time employees increase training and other costs, therefore, encourage fewer part time employees to save money.
4. WIC clinics might best be located where clients travel to buy food, or at Wal-Mart, etc.
5. Consider a "WIC van" to take services to areas with few clients.

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5. Problems: ***Local agencies do not have adequate funds to maintain the caseload, provide quality services, and complete all administrative requirements.***
The system relies on local contributions in order to maintain current caseload.

Jane Smilie led the group to identify mutually agreed upon guidelines for the funding formula based on the work of the study group so far. Here is the list:

1. Incentivize client participation for leads and non-leads.
2. Keep and incentivize regional work (lead agencies).
3. Cap cost per client or create a flat rate per client.
4. Pay for performance.
5. Programs with under 200 clients > move to a regional approach.
6. Clarify/identify lead responsibilities.
7. Implement cost saving innovations.
8. Consider clinics where food is purchased.

Proposals from the DPHHS WIC staff, and ad hoc group from the Study Group, MAWA, and AMPHO were considered by the group. Linda Best led the group through the guiding principles developed by the ad hoc group:

Guiding principles:
- Has to be fair - $172 per client is the state average cost per participant.
- Need to have adequate base funds to support basic service.
- Take into consideration lead costs.
- State needs to look at cost cutting on their end.
- Large programs also need to look at inefficiencies.
- Developed by reps of AMPHO and MAWA.
- Assumptions – last year's funding, $84,000 carry forward, state asks for additional $100,000 as proposed for '09.
- Avoids contract modifications.
- Simple to adjust.
- Provides incentives for leads.
- Provides a base for stand-alones.

An Excel spreadsheet was projected and edited until consensus on a funding formula was reached. The end product includes elements of all proposals. The agreed-upon matrix reflects the formula and is presented at the group recommendation.

Recommendations: 1. Funding formula

FFY 09 Proposed WIC										5/7/2008
Contractor Allocation										
	2007 Clients Served	Base Rate of	Clients Served X Cost Per Client of	Regional Lead Agency Support	Total of Base Rate + Client Cost + Regional Lead = Proposed Contract Award FFY 09	Actual Total Contract Award FFY 08	Difference from Actual 08 and Proposed 09	2008 Cost per client (from state worksheet)	2009 Cost Per Client	Difference in per client costs from 08 actual to 09 proposed
WIC CONTRACT CALCULATIONS		2000	171	4000						
Region 2 - BROADWATER	228	$ 2,000	$ 38,988	$ 4,000	$ 44,988	$ 43,375	$ 1,613	$ 190.24	$ 197.32	$ 7.07
Region 3 - CASCADE	1,932	$ 2,000	$ 330,372		$ 332,372	$ 303,755	$ 28,617	$ 157.22	$ 172.04	$ 14.81
Region 4 - CUSTER/DEAP	656	$ 2,000	$ 112,176	$ 4,000	$ 118,176	$ 112,928	$ 5,248	$ 172.15	$ 180.15	$ 8.00
Region 5 - DAWSON	183	$ 2,000	$ 31,293	$ 4,000	$ 37,293	$ 36,509	$ 784	$ 199.50	$ 203.79	$ 4.28
Region 6 - DEER LODGE	479	$ 2,000	$ 81,909	$ 4,000	$ 87,909	$ 87,581	$ 328	$ 182.84	$ 183.53	$ 0.68
Region 7 - FERGUS/HRDC	235	$ 2,000	$ 40,185	$ 4,000	$ 46,185	$ 44,452	$ 1,733	$ 189.16	$ 196.53	$ 7.37
Region 8 - FLATHEAD	1,536	$ 2,000	$ 262,656		$ 264,656	$ 246,822	$ 17,834	$ 160.69	$ 172.30	$ 11.61
Region 9 - GALLATIN	1,099	$ 2,000	$ 187,929	$ 4,000	$ 193,929	$ 180,452	$ 13,477	$ 164.20	$ 176.46	$ 12.26
Region 10 - HILL	456	$ 2,000	$ 77,976	$ 4,000	$ 83,976	$ 79,321	$ 4,655	$ 173.95	$ 184.16	$ 10.21
Region 11 - LAKE	574	$ 2,000	$ 98,154		$ 100,154	$ 96,410	$ 3,744	$ 167.96	$ 174.48	$ 6.52
Region 12 - LEWIS & CLARK	1,149	$ 2,000	$ 196,479		$ 198,479	$ 184,418	$ 14,061	$ 160.50	$ 172.74	$ 12.24
Region 13 - LINCOLN	456	$ 2,000	$ 77,976		$ 79,976	$ 82,496	$ (2,520)	$ 180.91	$ 175.39	$ (5.53)
Region 14 - MISSOULA	2,732	$ 2,000	$ 467,172	$ 4,000	$ 473,172	$ 434,792	$ 38,380	$ 159.15	$ 173.20	$ 14.05
Region 15 - RAVALLI	801	$ 2,000	$ 136,971		$ 138,971	$ 136,287	$ 2,684	$ 170.15	$ 173.50	$ 3.35
Region 16 - SANDERS	290	$ 2,000	$ 49,590	$ 4,000	$ 55,590	$ 55,225	$ 365	$ 190.43	$ 191.69	$ 1.26
Region 17 - SHERIDAN	293	$ 2,000	$ 50,103	$ 4,000	$ 56,103	$ 55,750	$ 353	$ 190.27	$ 191.48	$ 1.20
Region 18 - BUTTE-SILVER BOW	802	$ 2,000	$ 137,142	$ 4,000	$ 143,142	$ 133,949	$ 9,193	$ 167.02	$ 178.48	$ 11.46
Region 19 - TETON	496	$ 2,000	$ 84,816	$ 4,000	$ 90,816	$ 91,258	$ (442)	$ 183.99	$ 183.10	$ (0.89)
Region 20 - VALLEY (FRANCES MAHON DEAC)	256	$ 2,000	$ 43,776	$ 4,000	$ 49,776	$ 49,278	$ 498	$ 192.49	$ 194.44	$ 1.95
Region 21 - YELLOWSTONE	2,939	$ 2,000	$ 502,569	$ 4,000	$ 508,569	$ 463,744	$ 44,825	$ 157.79	$ 173.04	$ 15.25
Region 22 - FORT PECK	614	$ 2,000	$ 104,994		$ 106,994	$ 105,998	$ 996	$ 172.64	$ 174.26	$ 1.62
Region 23 - NORTHERN CHEYENNE	528	$ 2,000	$ 90,288		$ 92,288	$ 89,544	$ 2,744	$ 169.59	$ 174.79	$ 5.20
Region 24 - BLACKFEET	705	$ 2,000	$ 120,555		$ 122,555	$ 116,821	$ 5,734	$ 165.70	$ 173.84	$ 8.13
Region 25 - CROW	628	$ 2,000	$ 107,388		$ 109,388	$ 109,269	$ 119	$ 174.00	$ 174.18	$ 0.19
Region 26 - SALISH & KOOTENAI	458	$ 2,000	$ 78,318		$ 80,318	$ 83,310	$ (2,992)	$ 181.90	$ 175.37	$ (6.53)
Region 27 - FORT BELKNAP	313	$ 2,000	$ 53,523		$ 55,523	$ 58,423	$ (2,900)	$ 186.65	$ 177.39	$ (9.26)
Region 28 - ROCKY BOY	327	$ 2,000	$ 55,917		$ 57,917	$ 58,782	$ (865)	$ 179.76	$ 177.12	$ (2.65)
Totals		$ 54,000	$ 3,619,215	$ 56,000	$ 3,729,215	$ 3,540,949	$ 188,266			
NOTES	All caluculations above are based on clients served in a sample period in 2007. Actual amounts will be recalculated									
	based on clients served between March 31, 2007 and April 1, 2008.									
	This budget is based on the assumptions that the state will carry over $84K from 2008 and will request and receive									
	a $100K increase in OA funds in 2009.									

The period of time to establish caseload averages will be October 2007 through March 2008.

2. Information to be provided by DPHHS to locals to help get county funds – messages - food for moms and babies/WIC funds support local economies.
3. Evaluate need to downsize administration on state and local levels due to plan and SPIRT implementation and subsequent efficiencies.

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6. Problem: Confusion about WIC requirements and training and problem solving is a burden on vendors, local agencies, and the state, and there is a risk of losing more vendors.

Recommendations:

1. Information that checks for items which are not the "least expensive" will be rejected - this must be explained to vendors.
2. The SPIRIT system will help with this problem – should be functional in the fall of 2009.
3. Design informational training/webcasts for vendors to view at a time that works for them.
4. Local staff must be trained so that they can train vendors, so that employees can be trained.
5. When new food package comes out, make regional training available.
6. Vendor could show a WIC DVD to employees with a check off or test to be completed when viewed.
7. Develop bulleted points for education (PowerPoint slides).
8. Newsletter, frequently asked questions.
9. Get the word out about what the state is doing and what is working.
10. Develop template for grocers to plug in least expensive food – use white tags for easy identification by clients.
11. Make the new food list easy to understand.
12. Let everyone (locals, vendors) know what the consequences will be up front.

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7. Problem: Some clients are seen more often than necessary.

Recommendations:

1. Move to 3 months of checks for a low risk client who is certified, client can come to drop in clinic or staff can send education material (interactive education), staff can mail checks every 3 months which means clinic will see clients twice per year.
2. For clinics that are seeing clients every month, state to move them to see medium and low risk clients 4x/year as an improvement.
3. State to warn clinics that funding is moving to cost per participant as recommended by the Study Group and suggest ways to become more efficient.
4. Establish standards for Continuous Quality Improvement regarding appointments/day.

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8. Problem: Rising food costs.

Recommendations:

1. State to compare vendor peer group prices, vendor can be taken off of the program if foods are not within peer prices.
2. A task force to look at prices for the WIC Food Package and decide what types and brands will be encouraged will be convened by the state and will include grocery store representatives, natural food stores, the grocers association, food bank network, WEEL, farmers, and WIC employees.
3. Local agencies to educate clients on prices – ask "How is it going with least expensive?"

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9. Problem: WIC's identity is confused among clients, providers, and officials.

Recommendations:

1. Better outreach and marketing – a targeted outreach experiment is in process now with OA funds – report on effectiveness after conclusion.

2. WIC has significant name recognition – do more targeted outreach to providers, Offices of Public Assistance, and the community – message should be: WIC is nutrition education and food for participants.
3. The most successful outreach has been: Bring a friend to WIC.

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10. Problem: Time studies are time consuming.

Recommendations:
1. Field test new policies and/or forms before they are implemented statewide.
2. Review federal requirement for time studies.
3. Message to the feds: Garbage in, equals garbage out. Right now, this is costing the program $48,000 (15 minutes per day for one month, all local WIC agencies) and is probably not accurate or useful. This is a waste of time.
4. Review time study data – at the very least, we should get feedback on what is put into the system.
5. Determine what info would be valuable to collect and get feedback to locals/state that is truly useful.
6. Could this information be collected by SPIRIT or could the state use a formula to get this information to the feds?

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11. Problems: There is a communication problem among the local players (WIC Directors, Division Administrators, Health Officers, Lead Local Public Health Officials, Boards of Health, Tribal Health, etc.)
The communication structure between the state and local contractor (who signs the WIC contract) is ineffective.
No consistent, formal, sanctioned (we agree) forum exists for local input on state policy/funding development.
There is no formal communication structure from locals to the state.
Frustration with not being heard had led to the involvement of a myriad of advocacy groups - MAWA, AMPHO, MPHA, Family and Community Health Advisory Group (appointed by the Governor), WIC Futures Study Group, Steering Committee (now phased out), and Funding Formula Committee (now phased out).
Communication roles among WIC partners (contractors, non-profits, those who make referrals, County Commissioners, Boards of Health, Tribal Leadership) are not defined.

Recommendations:
1. Develop a formal communication structure:
    a. Require locals to identify in the WIC contract who they want information from the state to go to and to keep the state up to date if this information changes during the contract period. This should also be done as soon as possible.
    b. State to email all pertinent information once a week in a collective format (example: News Brief) to all identified contacts.
    c. Develop a formal representational group that meets at least 2 times/year for the purpose of: funding problem-solving; policy development; and data sharing, etc. Principles to go forward: two way communication, time to prepare, feedback to all, collaborative atmosphere. (The members of the WIC Futures Study Group agreed to continue their work for one year, meeting quarterly, then to meet 2 times/year and to become the group addressed in this recommendation.)
2. State to continue to educate all about Public Health and how WIC fits in.
3. State to institute a monthly (voluntary) 1 hour telephone conference call for more people than WIC directors.
4. Special calls for specific topics can be held with 2-way communication for questions/comments.
5. Survey Monkey should be used to develop call agendas.

6. MAWA, AMPHO, MPHA representatives to check with their groups to see if they feel they have input into the WIC process. They will report at the next meeting.
7. The WIC Futures Study Group membership may not change until spring of 2009 to give time for the effect of their recommendations to be evaluated.
8. The WIC Futures Study Group will hold a conference call with regional federal WIC representatives once per year.

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12. Problems: ***Data is not used to make the system work better or track participant outcomes.***
Monitoring visit results are not aggregated and shared with locals.

Recommendations:
1. Use WIC data to set goals and evaluate goals – what would be some measures of success in the WIC program and how can quality improvement strategies be brought to bear?
2. Track data – e.g. Hemoglobin lab tests, incidence of breastfeeding.
3. The SPIRIT system will collect better data but what to track must be defined before SPIRIT is in place.
4. Develop measures of efficiency.
5. Identify data that exists now at the local, state, and federal level and analyze the data currently available.
6. Frame some questions to be submitted to CDC for analysis of data they have.
7. State WIC program to develop and distribute an annual report about the program based on data collected from monitoring visits. This report should list areas of excellence as well as common deficiencies, and whether the overall program is meeting program requirements.
8. Information about food given out, prices, and funding should be distributed, as well as information regarding potential clients (example: Are we at market level?)

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13. Problems: ***Maintaining quality may be difficult with cost containment.***
There is a lack of a consistent definition and evaluation of quality.
There have been problems at the state and local level complying with audits.
We do not know what clients perceive of WIC services.

Recommendations:
1. Need to define what we mean by "quality" for clients, vendors, physicians, staff, and other partners.
2. Need to define components of quality and establish measures of quality (example: Is a local agency just providing the minimum requirements or is it a full-service clinic?)
3. Need to bring in the experience of the clients through satisfaction surveys.
4. Then set goals and work to improve quality.

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14. Problems: ***Clinics may not flow or operate as efficiently as they could.***
Too many signatures are required.
No shows are expensive and lead to inefficiency.
Doing non-required hematocrits, proof of pregnancy, and multiple code listings wastes time and increases costs.
Some clients are seen more often than necessary.
Inadequate basic program (best practices, lists, procedures, where WIC fits in Public Health) for training new employees, including directors.

Recommendations:
1. All WIC staff (state and local) need "Toyota Lean" training.
2. Clinics to assess clinic flow/processes and take action to improve efficiency and quality.
3. Get SPIRIT system up and running.

4. Signatures - before the system is in place, DPHHS will consult with the regional office to see if it is possible to combine things that now require separate signatures or if initials can be used. This information will be shared with all programs.
5. No shows -
    a. Pro-rate vouchers for missed appointments.
    b. Move to 3 months of checks so clients don't have to come in every month.
    c. Promote Kalispell model - same day scheduling three days out of the week, certifications are performed on the other two days on a walk-in basis.
6. Non-required tasks - state staff to discuss the removal of non-required hematocrits, proof of pregnancy, and multiple code listings as necessary tasks, and alter the State Plan, accordingly.
7. Clients seen more than necessary - consider alternate methods of service delivery:
    a. Remote access with webcams for CPA certification.
    b. Require 3 month issuance of checks except for high risk clients.
    c. For a certified client, when they have used the last check, they can contact through email or phone and next 3 checks will be sent to them.
    d. Provide guidance to locals about what alternative methods can be implemented.
8. Inadequate orientation/basic program training –
    a. Develop an orientation checklist and determine what training should be done in person and what could be done over TCC or similar format.
    b. Post important documents on the WIC website.
    c. Set up mentoring visits for new directors.
    d. Develop WIC-specific orientation for RDs.
    e. Local Agency Retailer Coordinators would receive additional training on vendor issues.
    f. Assure the above tasks are done.

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15. Problems: Local funding is not distributed in a way that rewards performance and responsibility. There are local agencies that consistently do not meet minimum requirements.

Recommendations:
1. Identify a basic level of performance.
2. Pay for caseload. This will dis-incentivize poor performance.
3. Research other financial sanctions in other states.
4. Tribal approach – a decrease in WIC funding must be made up by the tribe, the WIC program does not suffer. The tribe will then review staff performance.
5. Research positive incentives – these may be made in relation to quality (example: a cash incentive for a good monitoring report)
6. Let funding formula work and evaluate after one year.
7. Reward regional agencies for their size (maintaining and increasing caseload/meeting standards)
8. Set goal of no legislative audit exceptions.

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16. Problems: Sometimes program process overrides client needs. There is no established mission or set of guiding principles.

Recommendations:
1. Draft a mission statement and guiding principles at the next meeting and send it out for review.
2. Before the next meeting, survey all regarding what words must be included in Montana WIC mission statement and bring this to the meeting.

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17. Problem: Service funding is increasingly going toward state administration.

Recommendations:
1. Make observation about the importance of WIC funding to moms and kids.
2. State administrative costs (like IT) should be reviewed annually and kept to a minimum.
3. Legislature should allocate administration support.
4. Data is needed to advocate effectively.
5. Check for foundation help.
6. Maximize the Medicaid match.
7. Utilize "Toyota Lean" approaches to generate solutions.

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18. Problem: The current system and regulatory nature of WIC lead to perceptions of micromanagement.

Recommendations:
1. Field test new policies and procedures before they are institutionalized.
2. If a question is asked by local staff, post the question and answer on the website.
3. Stay on top of what is required and what is not required.

Agenda for Next Meetings

The group decided to schedule two meetings, one to be held in September and one to be held in October.

The next meeting will be held Wednesday, September 24, 2008 in Helena. Location TBA.

Proposed agenda topics:

Progress Report on Recommendations
Report from Representatives from MAWA, MPHA, and AMPHO
Development of a Communication Tree
Report on the Inventory of Data Sources and Development of Questions to Ask CDC
Discussion/Decisions Regarding the SPIRIT System: What do we want to measure?
Development of Mission and Guiding Principles

A subsequent meeting will be held Tuesday and Wednesday, October 28-29, 2008 in Bozeman. Location TBA.

Proposed agenda topics:

Discussion Regarding Structure for RD Services
Discussion Regarding Regional Staffing
Prioritize Proposed Solutions and Develop an Order or a Timeline to Address the Priorities
Discussion/Definition of Quality and Development of a WIC Quality Improvement Plan

Public Comment

Public comment was elicited and observers responded with positive comments about the Study Group activity and process of the meetings.

Evaluation

The Study Group members provided an evaluation of the sessions. In regard to what they liked, one participant mentioned the "detail we got to today." Several participants mentioned that they liked the process. One person noted the visual aspect of the process; they liked "seeing the pages move." Another was pleased that the process helped the group to "look at the whole." One person said the process allowed "everyone's input" and that "everyone talked." Another mentioned a sense of "encouragement and accomplishment "in which everyone participated. Others noted liking the direction we are going, moving forward in a positive way, and that the state staff had already started to implement suggestions. One person was really glad that "we made it through all of the problem statements." Several people liked the fact that the group decided to continue and members committed to another year on this project. Another liked the "communication piece." Another was excited about applying the "Toyota Lean" model to WIC and that the state may move forward with EBT. One person said they liked that the meeting was held in a place where you could take a walk. One person liked the momentum of the meeting. And another participant liked that direct billing was available for the rooms.

In regard to what should be changed, one person said the meeting room was cold and offered that a temperature of 74 degrees would be better. One participant said that they would have "gone back to make sure MAWA was a part of all of this – where to get the documents and checked that they felt included. One person wished they would have heard the information about the Toyota model that was offered at a recent public health training. One person wished the next two meetings were not scheduled so close together. One person wished that "it wasn't so much work, but it is worth it." She also noted that the group will learn more as it goes forward another year. And one participant said that it would be great to have a Star Trek "transporter" to aid travel from afar.